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Undisturbed Physiological Birth: Insights from Women Who Freebirth in the United Kingdom

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ABSTRACT

Objective: To understand women's experiences of undisturbed physiological birth by exploring the narratives of women who have freebirthed their babies in the United Kingdom (intentionally giving birth without midwives or doctors present).

Design: Unstructured narrative face-to-face interviews were carried out and data were analysed using the Voice Centred Relational Method (VCRM).

Participants: Sixteen women who had freebirthed their babies.

Findings: Women discussed a range of phenomena including birth positions, the fetus ejection reflex, pain, altered states of consciousness, physiological third stages and postnatal experiences that were physically and emotionally positive.

Key conclusions: There is a paucity of literature on physiological birth and limited opportunity for practitioners to witness it. Further research is required on phenomena related to physiological birth so as to better understand how to promote it within the maternity setting and when intervention is justified.

Implications for practice: Standard maternity settings and practice may not be conducive to or reflective of physiological birth. Better understanding of physiological birth is required so that pregnant women and people can be appropriately supported during labour and birth.

Introduction

In its recommendations on Intrapartum Care for a Positive Childbirth Experience, the World Health Organisation (WHO) (2018) recognised the importance of ensuring that women and their babies are able to thrive following birth and reach their full potential in life. Alongside this, it also recognised that increased medicalisation, predominant in recent decades, risks undermining both a woman's capability to birth her baby and her psychological experience.

The important and specific contribution of midwifery in the delivery of maternity care has been highlighted by Renfrew et al (2014). Developing their framework for quality maternal and newborn care, they identified that the promotion of normal processes and prevention of complications were key aspects. However, the context of care is significant in determining outcomes and experience for women. At either end of the spectrum, 'too little too late' in low and middle income countries and 'too much too soon' in high income countries can both cause harm

(Miller et al., 2016). Evidence suggests that the way midwives facilitate birth is influenced by their clinical experience, the type of unit in which they practise and the physical environment (Healy et al., 2020). Healy et al's review focused on the second stage of labour and in conclusion, recognised the 'dearth of evidence' relating to how midwives facilitate birth. What is clear however, is that in the presence of a healthcare professional, even physiological birth often involves some sort of intervention or management. Consequently, opportunities for midwives and midwifery students to witness undisturbed physiological birth are limited.

Downe et al (2018) established that one of the phenomena that matters to women in childbirth is the 'physical and psychosocial nature of birth as an embodied experience', yet little research has been conducted on women's experience of physiological birth and their emotional response (Olza et al., 2018). As the role of the midwife includes 'optimising normal physiological processes' (Nursing and Midwifery Council (NMC), 2019:4) it is imperative that midwives are fully cognisant of the

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physiological processes involved so they will be able to appropriately support birthing people and respond to any relevant complications.

Although freebirth has been explored empirically in previous studies (for example, [Feeley and Thomson, 2016](#); [Jackson et al., 2012](#); [Plested et al., 2016](#)), focus has largely been on women's motivations and issues of risk. The focus of our study was the experiences of women who freebirth in the UK and their narratives will be reported in detail elsewhere. However, women's accounts provided a unique opportunity to document and analyse their experiences of physiological birth. The purpose of this paper is therefore to present insights gained on women's experiences of undisturbed physiological birth recounted as part of our study. As far as we are aware, this is the first time such evidence has appeared in the midwifery literature. We believe it makes an important contribution to a gap in the evidence that will be of particular interest to the readers of this journal.

A note on definitions

It should be noted that there is continuing ongoing debate around the terminology and definitions used to describe birth without any form of medical intervention. Whilst we initially used the term 'physiological birth' the only relevant definition we found was reported by [Olza et al. \(2018\)](#) as an 'uninterrupted process without major interventions, such as induction, augmentation, instrumental assistance, caesarean section as well as use of epidural anaesthesia or other pain relief medications.' However, this is not an entirely appropriate definition for the experiences of freebirthing women as highlighted in this study. Instead, we have opted for the term 'undisturbed physiological birth' and we welcome further academic and midwifery discussion on this point.

Methods

Sixteen women were recruited via online homebirth and freebirth Facebook groups to participate in in-depth narrative interviews exploring their experiences of freebirthing in the United Kingdom (UK).

Freebirthing was defined as occurring when a person intentionally gives birth without health care professionals (HCPs) present. The recruitment flyer invited interested women to contact the first author via email. Interest in the study was keener and quicker than expected and not all potentially interested participants could be interviewed. Those that could be reached via national public transport were prioritised and interviewees were geographically spread throughout England. Although it was presumed that snowballing would be required this was not needed during recruitment. Ethical approval was granted by the King's College London PNM Ethics Committee on 8th October 2019, number HR-19/20-13511. All interviewees provided written, informed consent before participating in the study.

All interviews were face-to-face, unstructured and carried out by the first author. One interview took place at the first author's home, ten at interviewees' homes and five at a neutral place such as a community centre. Participants were encouraged - although not required - to consider their experiences against the context of four stages: pre-freebirth pregnancy experiences; the freebirth pregnancy; the freebirth; and the postnatal experience. All interviewees were asked one question: "Please describe your freebirthing journey from any point you think most appropriate." As women discussed their experiences, the first author probed areas she felt needed greater clarification. Interviews lasted between one and two hours, were audio-recorded, transcribed verbatim and anonymised. Interviewees chose their own pseudonyms according to alphabetical order, i.e. the first interviewee suggested a name beginning with 'A', the second 'B' etc.

Reflexivity

Interviewees were aware that the project was supported by the national charity AIMS (Association for Improvements in the Maternity

Services). Participants were also informed that the first author is not a health care professional and is a volunteer at the organisation. This role reflects her academic background in law, human rights and ethics. It includes producing a range of written literature for the charity in addition to supporting women via the AIMS helpline to navigate the maternity system. The second author is a midwifery academic who used the Voice Centred Relational Method for her own PhD study. Her original midwifery education and clinical practice were mostly based in a Consultant Obstetric Unit in which the biomedical model was the norm.

Analysis

Analysis was conducted by the first author but discussed with the supervisory team, which includes the second author. The data were analysed using the Voice Centred Relational Method ([Brown and Gilligan, 1992](#)). This feminist methodology is based on literary and psychological theory and requires four 'readings' of the interview transcripts. These are iterative and aim to privilege the 'voice' of the interviewee. The first reading explores the plot contained in the narrative and the researcher's response to it; the second draws on the 'voice of the I' to discover how women position themselves in their story; the third analyses the relationships within the data; and the fourth places the narratives against the wider socio-cultural context ([Mauthner and Doucet, 1998](#)).

It should be noted that VCRM does not involve thematic analysis. It does however provide a structured framework for close and systematic examination of interviewees' narratives with an emphasis on their 'voice' and their attempts to be authentic, heard and not self-silence ([Brown and Gilligan 1992: 29](#)). Working from electronic versions of the transcript the first author analysed the text by drawing out relevant information pertaining to the requirements of each of the four readings. This article focusses on women's accounts of undisturbed physiological birth during their freebirthing experience. The results draw heavily on the first and third readings and use the fourth reading to assess these against the context of existing midwifery and obstetric knowledge.

Findings

All interviewees recounted aspects of their labour and birth in response to the initial opening question. With the exception of one interviewee, participants recalled their experiences chronologically, with those women who had previously given birth beginning their stories from either their first pregnancy or live birth. Demographics of participants were not collected due to ethics restrictions and the potential for published characteristics to reveal participant identities, particularly if results are shared within small online freebirth communities.

We can report however that the earliest freebirth had taken place seven years prior to the interview and the most recent only three months previously. [Table 1](#) demonstrates the number of births women reported and when not freebirthing, where they had previously given birth. The combined number of children within this cohort was 39, and all women reported freebirthing one child. All freebirths were of singleton babies with cephalic presentation. Four participants had freebirthed their first babies, while all other participants had freebirthed their youngest child. While it is not the purpose of this paper to discuss women's motivations, notably with the exception of those who had freebirthed their first babies, women gravitated towards less medicalised environments as they became more experienced in childbirth.

With regards to the support women had, seven participants had hired doulas, but only five of them managed to attend the birth. In common with findings in the meta-synthesis by [Olza et al \(2018\)](#), social support was an important part of the process of labour and birth. Fifteen of the women had their partner or husband for support during their freebirth, while one interviewee's sister was her birth partner. Some participants chose to have additional female support during their freebirth, and this included mother, cousin, friend, daughter and in one case a photogra-

Table 1
Births.

Participant pseudonym	First birth	Second birth	Third birth	Fourth birth
Alicia	Hospital	Hospital	Homebirth	Freebirth
Bianca	Hospital	Freebirth	-	-
Cat	Homebirth	Freebirth	-	-
Danielle	Hospital	Homebirth	Freebirth	-
Elsie	Hospital	Homebirth	Homebirth	Freebirth
Fionnuala	Homebirth	Freebirth	-	-
Georgia	Freebirth	-	-	-
Heather	Homebirth	Homebirth	Freebirth	-
Ivy	Freebirth	-	-	-
Jiskra	Homebirth	Freebirth	-	-
Kitty	Hospital	Freebirth	-	-
Leah	Hospital	Homebirth	Freebirth	-
Marion	Freebirth	-	-	-
Nadia	Hospital	Birthing Centre	Birthing Centre	Freebirth
Ophelia	Hospital	Homebirth	Homebirth	Freebirth
Polly	Freebirth	-	-	-

pher. Without prompt, four women noted their desire for female companionship during birth.

Maternity care

As women who decided to freebirth, the participants in this study may have appeared to be disengaging from maternity services. All interviewees however accessed maternity provision at some point in their freebirth journey, although in one case this was only during the post-natal period. Interactions took place with a range of HCPs, including obstetricians, GPs, health visitors, paramedics, paediatricians, sonographers, midwives of various levels of seniority, student midwives and doctors. Therefore in this cohort, and in common with most of the freebirth literature explored in the meta-narrative by McKenzie et al (2020), women were not 'anti-medicine'. They all accessed various health services at some point within their freebirthing journeys and were willing to seek professional help during their pregnancy if they feared a potential medical issue. Cat for example, reported reduced fetal movements and underwent additional doppler monitoring. Heather had two additional scans and also went to hospital to check reduced fetal movements at 40 weeks. Polly attended hospital due to bleeding early in her pregnancy. Jiskra had an additional scan for a low-lying placenta and Kitty, although paying for antenatal care from an Independent Midwife, saw an NHS consultant to discuss any potential consequences of having a previous 3b perineal tear. Consequently, women in this cohort were open to involvement from HCPs when they felt it appropriate to access those services.

Labour

Although in the maternity setting, childbirth is considered as encompassing three 'stages' of labour (National Institute for Health and Care Excellence (NICE), 2014; WHO 2018), these stages are a clinical construct used to advise on progress and appropriate management. Physiologically, labour is a continuum from the end of pregnancy to expulsion of the placenta and membranes (Howie and Watson, 2017). Notably, women in our study did not describe their labours in language associated with the bio-medical model of childbirth. There was no reference to first, second and third stages of labour or dilation. Only three women initially timed their contractions before abandoning the idea as their labour progressed. Women did not typically note the duration of their labours. However, when they did, this ranged from at least "40 hours," to a whole labour and freebirth that consisted of "about ten contractions." In a previous account of physiological birth, 'mechanical descriptions' of changes to a woman's body were also absent from descriptions of the subjective experience of labour (Olza et al., 2018). Dixon et al (2013) recognised that although the stages of labour may be common knowledge as women

approach birth, they have little meaning for women during labour and note that emphasis on cervical dilatation and elapsed time lead to the undervaluing of a woman's intuition and experiential knowledge.

None of the women in this cohort had the use of midwifery or obstetric skills, technology or equipment. Nevertheless, women frequently mentioned understanding the movement of their babies during labour and birth. As far as we are aware, there is little exploration of this knowledge within the literature. The physical connection a woman may have with her unborn child and the embodied knowledge she may possess with regards to the positioning of her baby and its readiness to be born is an interesting aspect of some of the narratives in this study.

Polly provided an example. About an hour before her baby was born, she noted the following during labour:

"And then, all of a sudden, I felt this real turn in my belly, and you could see, um, like it changed shape. And then I went, 'Right, that's it. He's in the right position now.'"

Kitty recalled a similar sensation:

"I know that the rest of the baby's coming, 'cause she had already rotated in me at this stage, um, which was a very interesting feeling, um, that sort of natural rotation of her, you know, moving face, face-up..."

Nadia described her experience of this and her sense of embodied knowledge as "psychedelic moments":

"there were like lots of psychedelic kind of moments where you just-, like I could see the baby and I could actually feel the baby, like, turning and coming down, and every little bit I felt."

Understanding embodied knowledge respects the act of listening to women, whilst also recognising them as important sources of information on their own bodies, labours and births. Disregarding embodied knowledge is one interpersonal factor that can contribute to women's psychological trauma during childbirth (Reed et al., 2017).

Pain

None of the women in this study used pharmacological pain relief. Participants described managing the pain of labour in various ways including reflexology, hypnotherapy, aromatherapy, prayer, massage, water, singing, remaining mobile and the use of birth balls and heat packs. Only one participant spent any time during labour resting in bed. Six participants noted their use of affirmations, with emphasis on words such as 'open' and 'surrender'. Three women stated that they had used birth imagery or visualisations during labour.

Women's descriptions of labour included attempts to verbalise the pain or intensity of uterine contractions or 'surges.' Polly compared the pain she experienced to the type of pain associated with injury:

“... it was intense and yes, it was full-on, but it didn’t-, I don’t look back and think, ‘That was pain,’ in the same way as, you know, I trapped my finger in the door the other week, and I was, like, ‘That was painful.’ But it wasn’t-, just not even-, pain wasn’t even the right word for it. It was like an amazing intensity but not-, and yes, it was hard, but not-, I could do it, you know.”

The differentiation between labour pain and pain from other causes has been noted in previous studies and the language reported is remarkably similar. There is recognition that labour pain defies description (Lundgren and Dahlberg, 1998; Whitburn et al., 2014) and is contradictory (Lundgren and Dahlberg, 1998; Thies-Lagergren et al., 2020; Whitburn et al., 2014).

‘Intense’ is a frequent descriptor that appeared in other women’s accounts in our study. Ivy did not experience *“pain, as such, it was just super intense.”* During labour, when Leah moved to use the toilet *“...the surges would get 100 times more intense.”* The intensity of the contractions surprised both Marion and Fionnuala. While the pain was *“very intense and all-consuming,”* for Alicia her freebirth was the *“least painful”* of her four births. Conversely, Jiskra reported the pain of her freebirth as worse than that of her previous homebirth. For Georgia, *“the contractions for the placenta were a lot worse than labour.”*

With regards to where women felt pain and how it impacted them physically, women described very different sensations. Cat noted that the worst pain was in her cervix, yet for Nadia the pain became *“much more stronger into the stomach.”* Three women reported that their labour pain was accompanied by vomiting and/or diarrhoea.

Altered state of consciousness

Although not all participants had practised hypnotherapy, some interviewees recalled entering a particular mental space while contracting. Alicia spoke of entering *“wonderland,”* Kitty of *“labourland,”* Polly of *“dreamland”* and Marion of a *“faraway land, different realms that were really comforting between my contractions.”* Leah described mentally entering a *“primal zone internally”* and Ivy, Cat and Polly commented on how during labour they had lost all sense of time.

From her work on women’s experiences of the second stage of labour initially conducted over 20 years ago, Tricia Anderson had recognised the altered state of consciousness that enabled women to ‘let go’ so that their bodies could take control (Anderson, 2010). Like Ivy, Cat and Polly, all the women in Anderson’s study had described a sense of timelessness or time distortion. More recently, Olza et al (2020:11) have suggested that an altered state of consciousness may be a ‘hallmark of physiological birth in humans’. They suggest this is mediated through neurohormonal pathways, with oxytocin having an important role. Labour pain is not just sensory but also has emotional and cognitive elements that contribute to women’s experience (Klomp et al., 2017).

Birthing position

There is a range of international research exploring the optimum position for women to give birth, yet in a recent Cochrane Review, these studies have been considered as generally not being of good quality (Gupta et al., 2017). Further, all of these reported births took place in the presence of HCPs and frequently in hospital environments. Problematically, it is unknown what effect the presence of a doctor or midwife has on the behaviour of a woman in labour and particularly on the birthing position she may adopt. Unusually, in this cohort, women gave birth without medical instruction or guidance and in environments that they had prepared for themselves, which were specific to their own personal needs.

The birthing positions women in this cohort reported were strikingly similar. No woman birthed on her back, side or in any position in which she was physically supported by another person. This situation is also evidenced in the photographic records of Becky Reed (2016), whose

experience is that, left to their own devices, women rarely choose supine or semi-recumbent positions for birth, but mostly adopt positions on all fours or kneeling. No participant in our cohort gave birth standing up. With the exception of Ivy who did not explicitly use the word ‘kneel,’ every woman in this cohort adopted a low, leaning forward position which incorporated some form of kneeling.

As highlighted in Table 2, women birthing in a pool leaned forwards over the edge with the bottom halves of their bodies submerged in the water. Those birthing on land adopted a similar position, but used the end of the bed, the headboard, a wash basket, or the backrest of the sofa. Two women did not report leaning on any form of support but did describe upright kneeling positions.

Birthing the baby

In this study, thirteen out of the sixteen participants described speedy, instinctive births that appear to reflect the fetus ejection reflex. Odent (2016:20) describes this as ‘a very short series of irresistible, powerful and highly effective uterine contractions, without any room for voluntary movement’. Apart from Odent’s work, the fetus ejection reflex rarely features in obstetric or midwifery literature, and women’s experiences of it are totally absent. In Odent’s (1987) view, it is the environment and the undisturbed nature of the birth that are crucial factors in the occurrence of the fetus ejection reflex.

He depicts a situation in which there is no conscious, active pushing: the baby is effectively expelled from the mother’s body. This is reflected in our narratives. Leah described how:

“...baby came so quick, just after a few big breaths, and I didn’t even feel like I needed to push, it was just so-, just like baby glided out.”

Nadia commented that she felt she needed to *“just hum [baby] out, sing it out, breathe it out. You know there’s no need to push.”* Cat stated that she *“didn’t push at all.”* Ophelia also commented that *“there’s no need to push”* and for Georgia, after her baby’s head emerged, there was *“maybe ... 30 seconds”* before her baby *“just came out in one go.”* Marion only *“pushed for about one minute... it was really quick”* and Jiskra only pushed on instinct *“four”* times before her baby was born. After labouring throughout the day, Ivy experienced a 45-minute power nap in her birthing pool and on waking her *“body started, like pushing”* before her baby *“slipped out like a fish.”*

Women struggled to differentiate between what is typically perceived as ‘pushing’ and the sensation they were experiencing:

“It was, like, three pushes, if you call them pushes, just like breathing him down, and, um, and the second one, he’d like, his head was totally out.” (Bianca)

Attempts to describe the fetus ejection reflex indicated a lack of suitable terminology, perhaps reflecting the infrequency of physiological birth descriptions in mainstream discourse. Two women compared the sensation to vomiting:

“I didn’t really do anything, my body just pushed... I felt like, at the end of [a ‘push’], I’d sort of do a little, ‘Ooph,’ it felt like that, but I wouldn’t say I was pushing it was just, kind of, a, ‘Urgh,’ like, at the end... So, like, when you’re being sick you, kind of, go with it and try and get everything out.” (Ivy)

Alicia also attempted to verbalise her experience:

“I used to say with my friend, ‘I, sort of, vomited the baby out,’ because I remember the noise came out of my mouth, and I, sort of, imagined it coming out down there, as well. It was, sort of, like, ‘Ugh,’ with each contraction, but it was beautiful. It was really normal and no hard pushing...”

Ophelia emphasised the instinctive nature of the reflex:

Table 2
Birthing positions.

Participant pseudonym	Place of birth	Position
Alicia	Pool	One knee and one foot on floor
Bianca	Dry land	Kneeling on bed
Cat	Pool	Kneeling in pool
Danielle	Dry land	Kneeling and leaning against wash basket
Elsie	Dry land	Kneeling in bathroom on towel
Fionnuala	Dry land	Kneeling but sitting back on heels
Georgia	Pool	One knee and one foot on the floor
Heather	Pool	Kneeling but had to readjust her leg upwards to move baby's body out
Ivy	Pool	Leaning forward over the edge of the birth pool – but did not explicitly use the word 'kneel'
Jiskra	Pool	Kneeling over the edge of the birthing pool
Kitty	Pool	Kneeling over the edge of the birthing pool
Leah	Pool	Kneeling and then turned to semi-squat leaning back on birth pool
Marion	Dry land	Kneeling with top half of body leaning on the sofa
Nadia	Pool	Kneeling in the pool with top half of body leaning over the pool side
Ophelia	Dry land	Kneeling on bed and leaning against the headboard
Polly	Dry land	Kneeling over the edge of the bed

“Your body kind of does do a, ‘Err,’ it does it on its own and you can-, I was trying to go, ‘Let it do it,’ but you do have that instinct to go with it...”

Three women in this study recounted different experiences. First time mother Polly pushed for “*about 45 minutes.*” Her pushing was nevertheless instinctive as she reported only pushing when she “*felt the urge.*” Heather described “*pushing*” until she felt that her baby had become “*stuck*” and instinctively changed her position to dislodge him. This involved being in a hands and knees position and then instinctively raising one leg until she felt the baby “*move*” before he then “*shot out*” behind her in the pool. Similar behaviour is described by Becky Reed (2016) in which a woman instinctively lifted her leg on to the arm of a sofa which would have increased the space within her pelvis. The third exception is Danielle, who at the end of her labour, actively and consciously pushed her baby out. She described telling her husband “*I’m done.... I’m gonna get [baby] out*” suggesting tiredness had motivated her decision.

While it is not unusual for a baby’s body to appear quickly once the head is born, in this cohort, it is both the head and the body that appear without the ‘pushing’ that is typically perceived as accompanying childbirth. NICE (2014) indicates that the second or active stage of labour would be expected to last no more than three hours for a nulliparous woman and two for a multiparous woman, although ‘delay’ would be suspected much sooner. In this cohort, all interviewees reported second stages that were much quicker.

Birthing the placenta

In the UK, a prolonged third stage of labour is considered over 30 minutes with active management and over 60 with physiological management (NICE 2014: 1.14.3). Durations beyond this would typically invoke an intervention to expedite expulsion of the placenta. A UK study (Farrar et al., 2010) found that 93% of obstetricians and 73% of midwives “always or usually” employed active management in the third stage of labour. This raises questions about how frequently both midwives and students witness undisturbed physiological third stages. This study captured the diversity of women’s experiences with regards to the birthing of their placenta.

Twelve women discussed their experiences of birthing their placenta. As previously noted, women did not time this stage as would a midwife and therefore women’s recollections are approximate. The varying durations of this stage are provided in Table 3.

In this cohort, with the exception of Georgia who received an oxytocic injection at hospital, women’s experiences of birthing their placenta were straightforward. Women’s descriptions included highlighting how their placenta “*just plopped down,*” “*flobbered out like a big jelly*” and “*plopped out.*” One interviewee described hers as “*falling out.*” Two

Table 3
Approximate duration of third stage of labour.

Participant pseudonym	Time before placenta expelled
Bianca	30 minutes
Cat	“At least a couple of hours”
Danielle	1 hour
Elsie	About 90 minutes
Georgia	7.5 hours (visited hospital for oxytocic injection)
Ivy	One hour
Jiskra	1 and a quarter hours
Leah	Around two hours
Marion	5 hours
Nadia	40 minutes
Ophelia	“Nearly an hour”
Polly	20 minutes

participants “*tugged*” on the cord to remove the placenta but described no adverse consequences. As highlighted in Table 3, for the women who discussed the birthing of their placenta, there was no pattern or uniformity in the time taken for the placenta to leave their body. Notably, it was not uncommon for women to report third stages lasting longer than those recommended by NICE guidelines.

Post-natal experiences

None of the sixteen freebirths resulted in any major complications and no participant recalled undergoing suturing postnatally. However, one respondent described feeling “*very weak*” afterwards as she had “*lost a lot of blood*” and both she and another interviewee reported their bodies going into shock. One was revived with a pre-prepared herbal remedy of cayenne pepper and the second suggested that her body’s response was due to the speed of the birth.

During a postnatal check with a midwife, one woman discovered she had a second-degree tear. After experiencing second-degree tearing in a previous pregnancy and following a self-examination, another interviewee concluded that her freebirth had also resulted in a second-degree tear. Both women reported healing these tears naturally with two weeks’ bed rest (apart from toilet breaks and baths) and commented on no adverse effects. A third participant was not sutured and instead agreed with family members that they would provide her with a “*real, genuine 40-day postpartum*” meaning an extended period of rest and recuperation. She did however comment that “*the tear did not fully heal.*”

After being checked by HCPs postnatally, three women specifically reported having no tears, and in one case “*not even a graze.*” Heather commented on how different her postpartum healing had been in comparison to her previous births. She stated that post freebirth she felt “*so much better.*” Leah made a similar point:

"I couldn't believe how good I felt, because after my others I did feel a lot of stinging and stuff down there, but, I don't know, even a day or two after it was like everything had come back together so quickly. I just-, I was in shock, I was just like, 'This is mad.'"

Women reported undergoing a period of skin to skin contact as advocated by the Baby Friendly Initiative (Entwistle, 2013), but this was typically an instinctive response to catching their own babies and immediately drawing them close to their bodies. All of the women initiated breastfeeding immediately or soon after the birth. Polly, a first-time mother, commented on the ease at which her baby took to the breast:

"[baby] went straight to the breast and started breastfeeding straight-away."

Ivy, another first time mother, also commented on how she found breastfeeding *"really easy."* Kitty's experience was very instinctive:

"I just, sort of, sat there with the-, with the baby in my hand. Um, she, without my knowledge, latched onto me immediately. I was just holding her, and all of a sudden, there was something on my nipple, so she was very-, that was [a] very baby-led experience."

No interviewee mentioned the use of formula when feeding their newborns, although two women discussed seeking breastfeeding support and a third called midwives shortly after her freebirth to get some breastfeeding advice. The four youngest of the freebirthed babies at the time of the interview were all still breastfed, while four of the other participants commented that they had breastfed their freeborn babies for an extended period (beyond one year).

With regards to women's emotional response to their freebirths, interviewees reported very positive, if not euphoric feelings. Alicia stated that it was *"the most amazing experience of my entire life"* while Jiskra commented that it was a *"life-affirming experience"* and *"for six months following, I was on a high."* For Bianca it was a *"dream birth"* and for Cat the experience was *"amazing."* With regards to Kitty it has made her *"very confident in what I want for my children."* Similarly for Danielle, her freebirth made her feel *"very powerful"* and *"strong about my convictions."* Leah noted that it had made her baby a *"super calm little one"* and they *"have a stronger bond."* In this cohort therefore, undisturbed physiological birth was both a deeply impactful and positive emotional experience for all interviewees.

Discussion

There is a surprising paucity of obstetric and midwifery literature exploring undisturbed physiological birth and in particular, women's experiences of it. As far as we are aware, this is the first time freebirthing women's experiences have been presented as a way of understanding how women instinctively behave during childbirth and the physical and emotional effects associated with it.

This was a small-scale qualitative study and the results are therefore not generalisable. However, our findings provide a good starting point for further qualitative and quantitative research, particularly with regards to under researched areas such as the fetus ejection reflex. All the women in this cohort successfully freebirthed their babies and experienced positive outcomes. One area that remains unexplored however is the experiences of women who attempt to freebirth but for whatever reason decide to call a midwife or transfer to hospital prior to the birth of their baby. This area of investigation would particularly complement any future research exploring women's embodied knowledge.

While these results are in no way generalisable, they raise questions as to whether many existing maternity settings and guidelines are conducive to and reflective of physiological birth. This is particularly relevant with regards to the common use of beds on obstetric units which privilege supine and semi-recumbent birthing positions. The accounts of birth in this study raise questions as to why all of the women in this cohort experienced considerably shorter second active or 'pushing' stages.

In addition, the lack of obstetric and midwifery research on the fetal ejection reflex is a surprising and worrying gap in the literature given the frequency of its occurrence in this cohort of women experiencing instinctive physiological birth.

There is a dearth of knowledge reflecting how women experience labour pain and whether this is different to pain caused by injury. Existing literature focusses on pain management, rather than working with the pain. However, women who feel in control and work with the pain often feel much more positive about the experience of labour, even if the pain has been difficult to manage. For those people who wish to avoid epidurals or medicinal pain relief, understanding this may better help pregnant women prepare for and cope with the pain of childbirth.

Notably, there was a high frequency of successful breastfeeding in this cohort and more research is needed on any potential connection between this and undisturbed physiological birth. This is also relevant to the positive postnatal experiences interviewees reported in relation to both physical and emotional wellbeing.

Conclusion

Midwives and obstetricians seldom encounter truly undisturbed physiological birth. Our paper offers a rare insight into the experience of instinctive birth for women. Whilst there must always be research on ways to support women requiring medical and midwifery intervention, this cannot be appropriately done without a full understanding of all phenomena relating to straightforward physiological birth. The latter is the benchmark signifying why and when intervention is justified. An evidence base that is lacking in this area may result in overmedicalisation and this study contributes to the strengthening of that benchmark.

Conflict of interest

The authors declare no conflict of interests.

Ethical approval

Ethical approval was granted by the King's College London PNM Research Ethics Committee on 8th October 2019, reference HR-19/20-13511.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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